|  |
| --- |
| Patient’s Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ |
| Last First Middle |
|  |
| Patient’s Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Primary Phone # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| **DIAGNOSIS: Polycythemia secondary to Testosterone Replacement Therapy (TRT) ONLY**  **• Patients will be drawn to a minimum Hgb of 13g/dL for biologically born males or non-specified gender and Hgb of 12.5g/dL for biologically born females.**  *Disclaimer: We Are Blood (WrB) does NOT perform ferritin levels and cannot perform phlebotomy for a specific ferritin value.*  **• Draw 1 unit of whole blood (approximately 500mls)**  **Choose from boxes available.**  **Every 2 months** this frequency is highly recommended and will offer the most scheduling choices for the patient  Additional frequency options:  Every 4 weeks  Every 2 weeks  Patients meeting donor criteria may volunteer to donate their blood for the community as long as all donation criteria, including Hgb, is met at the time of donation. Patients who do not meet all donation criteria will be drawn as a therapeutic donation and their unit will be discarded and no additional tests will be performed on the patient or the patient’s blood. NO FEE will be charged for this phlebotomy for a diagnosis of Polycythemia Secondary to TRT. |

**CALL (512) 206-1265 FOR APPOINTMENTS OR QUESTIONS**

**Physician Certification:** I certify that this patient is under my care and has been diagnosed with **polycythemia secondary to testosterone therapy**. To my knowledge, the patient does not have any other bleeding disorders/ blood diseases or blood conditions. The patient’s physical condition is such that the phlebotomies should not affect them adversely.

**I understand that this order will automatically expire 1 year from date of physician signature or upon receipt of updated orders. Contact We Are Blood for alternate orders if patient does not meet all stated criteria.**

**PHYSICIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHYSICIAN’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone# (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax# (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax or email completed order form to 512-206-1365 or WrBClinicalServices@weareblood.org**

For WrB Clinical Services Use ONLY- TTCX Enrollment

DID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Existing TTCX comment?  Yes  No Previous THER?  Yes  No

Existing Deferral for any reason other than TT?  Yes  No Medical Clearance required? Yes  No

Qualification:  TTCX  THER (Deferral posted by/date:\_\_\_\_\_\_\_\_\_\_) Re-entry Date:\_\_\_\_\_\_\_\_\_\_\_  N/A

TTCX Comment posted by/date: \_\_\_\_\_\_\_\_\_\_\_\_\_  N/A CS Management Review:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Revision History

| **Revision No.** | **Effective Date** | **Description** | **DCC No.** |
| --- | --- | --- | --- |
| .01 | 06-17-20 | New form | 19-168 |
| .02 | 04-20-22 | Updated header reference. Removed “additional comments will void the form”. Added section to WrB CS use only section to document deferral posting, if applicable. | 22-004 |
| .03 |  | CR-21-0027 BBCS Upgrade. Clarified Hgb requirements based on gender options. | 22-073 |